Health Reform: Entry to Coverage

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Figure 1

Promoting Health Coverage

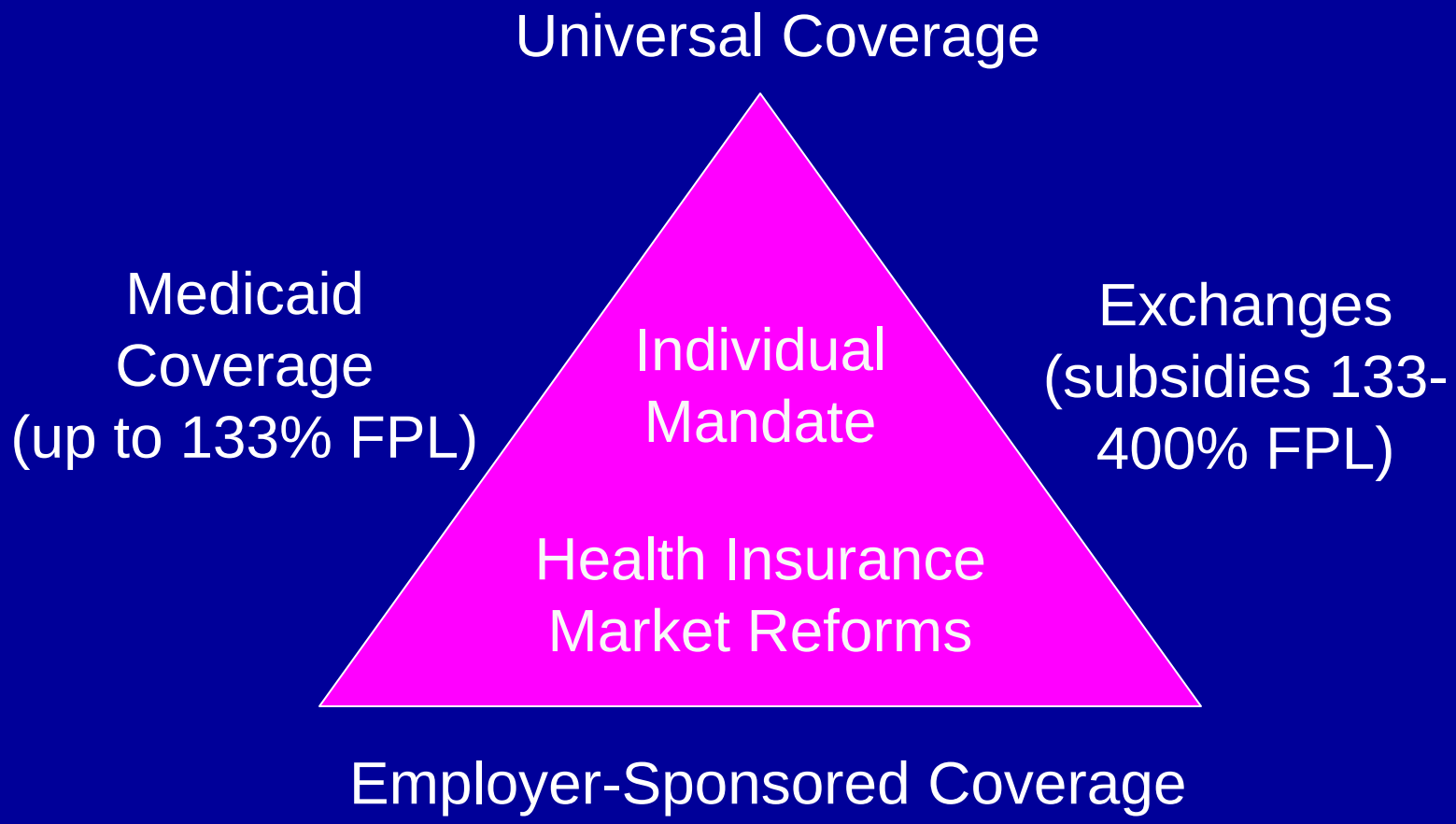
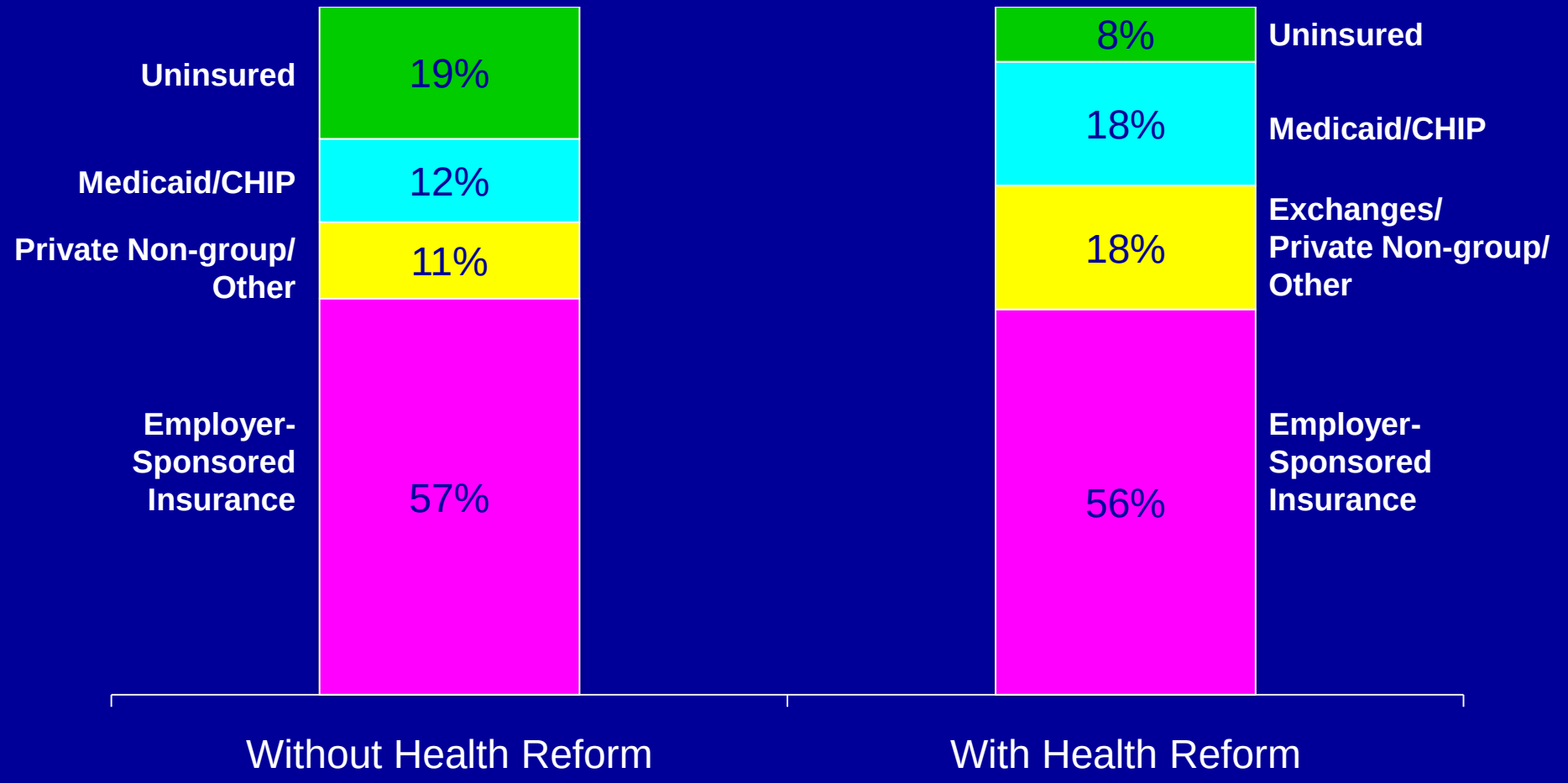


Figure 2

Health Insurance Coverage under Health Reform

Total Nonelderly Population = 282 million



SOURCE: Congressional Budget Office, March 20, 2010

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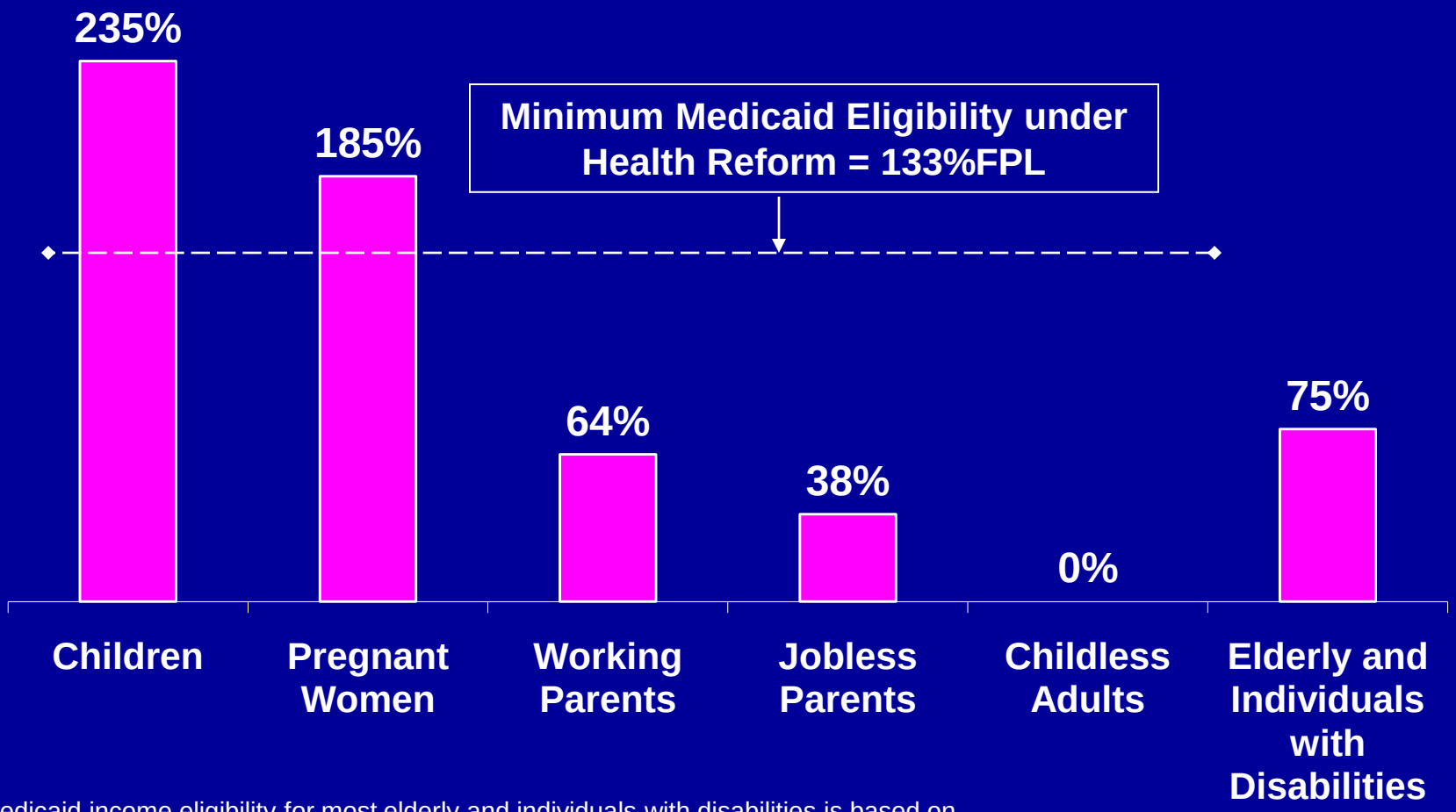
Figure 3

Medicaid Expansion

- Expands Medicaid to individuals with incomes to 133% of the federal poverty level in 2014 ($14,400 for an individual)
  - Eligibility based on Modified Adjusted Gross Income for most groups with no asset or resource test (5% income disregard applied)
  - Provides state option to expand Medicaid coverage to childless adults with regular match starting April 1, 2010
- Provides enhanced federal funding for newly eligible individuals
  - 100% covered by federal funds for 2014-2016, phases down to 90% by 2020
  - Phases in increased federal matching payment for states that have already extended coverage for childless adults
- Extends funding for CHIP through 2015 (2 year extension)
- Maintains Medicaid eligibility for adults > 133% FPL until 2014 and for children in Medicaid and CHIP until 2019

Figure 4

Median Medicaid/CHIP Income Eligibility Thresholds, 2009



Note: Medicaid income eligibility for most elderly and individuals with disabilities is based on the income threshold of Supplemental Security Income (SSI).
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for Kaiser Commission on Medicaid and the Uninsured, 2009.

Figure 5

The Health Insurance Exchanges

- Individuals without other coverage and small employers will be able to purchase coverage through state-based exchanges in 2014
- Standardized information to facilitate plan comparisons
- Premium and cost-sharing subsidies available
  - Premium tax credits for eligible individuals and families with incomes up to 400% of poverty ($88,000 for family of four) who purchase coverage in Exchanges
  - Cost sharing subsidies for those with incomes up to 250% FPL to reduce out-of-pocket costs
- Applicants must verify income and citizenship status

Figure 6

State Requirements / Options for Exchanges

- States must create exchanges by 3/23/2012
- Exchanges must be operational by 1/1/2014
- If states do not act, Federal government will establish the state-based exchange by 1/1/2013
- Exchanges can be non-profit or state-operated; can be multi-state
- Planning grants available to states for up to $1 million
  - Applications must be filed by Sept. 1, 2010
  - Assessing current information technology (IT) systems
  - Planning for consumer call centers
  - Developing partnerships with community organizations to gain public input into the Exchange planning process.

Figure 7

Requirements for Coordinated Enrollment Processes Across Programs

- Consumer-Friendly and Coordinated
  - "No Wrong Door" - Applicants are screened for all health subsidy programs and enrolled in the appropriate program
  - Seamless transition between programs
- Simplified
  - Uniform income rules and application forms
  - Use of data matching and verification
- Technology-Enabled
  - Web Portals (www.healthcare.gov)
  - On-line applications
  - Secure exchange of data across programs,

Figure 8

Potential Barriers to Coordinated Enrollment

- Time periods for determining income
  - Tax return for subsidy eligibility vs. point in time for Medicaid
- Enrollment periods
- Medicaid eligibility rules
  - Data match with SSA required for subsidy eligibility, optional for Medicaid
  - Many states require information on child support and third party liability for Medicaid that is not required for subsidies
  - States may require face-to-face interviews
- Renewal processes

Key Issues / Questions

- Where will eligibility determinations for Medicaid and Exchange be processed?
- Are there Medicaid rules that could be changed to better facilitate coordination with the Exchange (i.e. renewal periods)?
- How will changes in income and transitions between programs be handled?
- How can eligibility determinations for the non-MAGI population be coordinated with MAGI population?
- Are there lessons from administering CHIP or state funded health programs in how best to integrate enrollment, renewal and transitions?

Figure 10

Key Systems Issues

- Will current eligibility systems be able to accommodate Medicaid expansion and coordination with exchanges
- How will systems be designed to track “new” vs “current” eligibles for determination of FMAP?
  - New eligibles = 100% FMAP for 2014-2016
  - How will this affect enrollment simplification efforts?
- What will the FMAP be for developing new eligibility systems?
- Will systems be horizontally (linked to other public assistance programs) as well as vertically (linked to health programs) integrated?
- Will CMS develop prototypes for new system designs?

Figure 11

Enrollment Barriers for Low-Income Adults

- Lack of awareness of coverage and historic ineligibility for Medicaid
- Limited connections to public programs
- Fluctuating incomes
  - Move in and out of eligibility
  - Documentation challenges
- Language and cultural barriers
  - Literacy issues and lower education levels
  - Limited English proficiency and cultural biases
- Difficult-to-reach subgroups
  - Young adults aging out of children's coverage
  - Adults with complex health needs (including mental health needs)

Figure 12

How to Best Reach & Enroll Low-Income Adults

- Best practices for enrolling parents and children will apply, but reaching childless adults may require new messages and strategies
- Messages that focus on coverage availability and value of coverage
  - Convey they are newly eligible, “rules have changed,” they are “wanted” in coverage
  - Program name can make a difference
  - Focus on services covered and financial risks of being uninsured
- Partnering with CBOs and providers and using facilitated enrollment
- Utilizing new outreach avenues (e.g., unemployment offices, assisted housing and job training programs, shelters, food banks, colleges, literacy/GED programs, SSI offices)
- Coordinating enrollment processes and employing technology such as data matching and on-line applications

Figure 13

Coordination of Care Delivery System Requirements

- Limited requirements for coordinating delivery systems across Medicaid and Exchanges
  - Plans in Exchanges must contract with essential community providers, which may serve as access points for low-income populations
- Some coordination of benefits
  - An essential health benefits package created for Exchange coverage
  - Benchmark coverage for new elgibles in Medicaid must provide at least essential health benefits
- No requirement that plans/providers participate in both Exchanges and Medicaid

Figure 14

Coordination of Care Delivery System Questions / Issues

- Are there ways to ensure continuity in plans/providers across Medicaid and exchanges?
- How can enrollment in coverage be linked with enrollment in a plan?
- Are there requirements for plans that could help facilitate coordination in transitions (i.e. health assessments on file, plans of care, etc.)?
- Are there lessons from administering Medicaid managed care plans, CHIP plans or state funded health programs?

Figure 15

Summary

- Health reform creates new opportunities to provide coverage for millions of Americans
- New law requires eligibility and enrollment processes to be consumer friendly, simplified and to use technology but
  - Many questions to be answered through federal guidance
  - States have a lot of flexibility
- States will face challenging systems issues in moving forward with health reform implementation
- Many newly eligible will be adults without dependent children who have special enrollment challenges
- Many questions remain about how best to coordinate care across coverage types

For more information on health reform and additional resources for states:

www.healthreform.kff.org

www.statehealthfacts.org